Control #	Rev. Date:	Title:	Effective Date: 10/16
A 1.1		POLICY DEVELOPMENT AND REVIEW PROCESS	Next Review Date: 10/18

1.0 POLICY:

It is the policy of the Division of Public and Behavioral Health to ensure that all Division policies are relevant, effective, and current.

2.0 PURPOSE:

To establish a system for the development, review, approval and communication of Division policies

3.0 SCOPE:

Division wide

4.0 REFFERENCES:

NRS 433.314(1) (2)

5.0 DIFINITIONS:

5.1 Policy: DPBH Clinical Service Branch guideline or principles upon which a program or course of action is based.

5.2 Agency Protocol: Individual agency guidance that supports and adds clarity at the agency level for implementation of Division policy.

5.3 Procedure: Outline of established steps or specific method of completing desired outcomes or action. Discipline procedures will outline discipline specific processes. Discipline procedure will not duplicate Clinical Services Branch Policy or agency level protocol. Discipline specific procedures will cross walk across DPBH Clinical Service Branch agencies.

5.4 Policy Tech: Online policy and procedure management system used by the Division of Public and Behavioral Health to store track and manage agency policy and procedure.

5.5 Document Owner: The department lead assigned to create, monitor, maintain, and update agency policy. The document owner has the authority to delegate and assign writers, proxy authors, reviewers and readers.

5.6 Writer: Assigned by the document owner to write or collaborate in writing a document.

5.7 Reviewer: An individual assigned by the document owner to review a document for content accuracy and to provide input during the document development process.

5.8 Approver: The approver has final authority and responsibility for approving a policy for adoption by the division or agency.

5.9 Reader: A user assigned to read the policy. Readers have a responsibility to read policies as assigned and mark the policy as read to acknowledge that they have read and understand the contents of the policy. Policies may have short quizzes that must be completed prior to submitting "mark as read".

5.10 Reports: Policy Tech has the capacity to produce reports sorted by reader (employee) or document. Reports by **reader** allow a supervisor or other authority to view a list of all the documents "marked as read" by an employee. Reports by document allow management to view a list of all of the readers (employees) who have responsibility to read and acknowledge by "mark as read" that they read and understand a policy or procedure.

5.11 Document Control Administrator (DCA): Individuals assigned with the responsibility to manager user accounts (set user names, passwords and assign roles), upload and manage policies and procedures and create "reader groups."

6.0 PROCEDURES:

6.1 A new policy can be initiated by a Division Agency or by the Clinical Services Statewide Policy and Procedure Manager.

6.2 To avoid duplication of efforts, notify the Clinical Services Statewide Policy and Procedure Manager of the intention to develop the policy, and the proposed title or subject of the policy.

6.3 The Clinical Services Statewide Policy and Procedure Manager will forward for next agenda to the DPBH Clinical Services Policy Committee, ensure that the policy meets all regulatory and NRS requirements, and prepare it for submission to the Deputy Attorney General and the Commission on Behavioral Health for final review and approval.

6.4 When the policy is related to direct client or clinical care, the policy will be submitted for review by the Statewide Medical Director for Adult Mental Health Services

6.5 The Clinical Services Branch Statewide Policy and Procedure Manager will provide the initiating agency with:

6.5.1 Electronic copies of the format to be used (Attachment A);

6.5.2 Policy Review Form (Attachment B); and

6.5.3 Considerations for Policy Development and Review (Attachment C).

6.6 Development of the content of the policy will be enhanced by an inclusive process that provides an opportunity for review and comment from the range of staff within the agencies that are affected by the policy.

6.7 The draft of the policy is submitted to the Clinical Services Statewide Policy and Procedure Manager for further review, approval, and distribution process.

6.8 The document is to be marked "DRAFT," provided electronically in the specified format (Attachment A.). The policy originator's contact information is to be included. Do not include any dates at the conclusion of the policy; the appropriate date(s) will be added by the Clinical Services Statewide Policy and Procedure Manager.

6.9 The Clinical Services Statewide Policy and Procedure Manager will assign a policy number and submit the policy electronically to the DPBH Policy Committee for their opportunity for review and comment. Members of the DPBH Policy Committee will share the draft policy for

review with members of their constituency and will be the single voice to bring that input back to the committee.

6.10 Revision recommendation for the new policy must be received by the Clinical Services Statewide Policy and Procedure Manager using "track changes" by close of business the first Wednesday of each month for prior to review at next scheduled DPBH Policy Committee meeting.

6.11 Upon edit, review and approval of the policy, the Clinical Services Statewide Policy and Procedure Manager will submit the draft policy to the assigned Deputy Attorney General for review and input.

6.12 When the policy is related to clinical care it will also be submitted to the Chief Medical Officer and Statewide Psychiatric Medical Director. In the absence of a response from the Chief Medical Officer in seven (7) calendar days, the policy will be deemed appropriate to move forward to the Deputy Attorney General for final review.

6.13 Upon final review by the Deputy Attorney General, the Clinical Services Branch Deputy Director will have final review.

6.14 In the absence of revisions that affect intent or process the policy will then be prepared for submission at the next DPBH Commission on Behavioral Health for final approval.

6.15 When there are changes that affect intent or process, the policy will be routed for re-review by the DPBH Policy Committee.

6.16 Upon completion of all reviews, the policy will be submitted to the DPBH Commission on Behavioral Health.

6.17 To meet open meeting law requirements, policies must be submitted to DPBH Administration no later than three weeks prior to the Commission meeting. If received after that, they will be held for the next Commission meeting.

6.18 Upon approval by the Commission, the Clinical Services Statewide Policy and Procedure Manager will process the policy including ensuring that the policy is in the appropriate format, adding the approval date, and facilitating placement of the policy in Policy Tech.

6.18.1 To ensure communication about the new policy, the Clinical Services Statewide Policy and Procedure Manager will assign the policy to all appropriate reader's groups in Policy Tech.

6.18.2 It is the responsibility of each Agency Director and the DPBH Policy Committee Members to ensure that agency reader's groups are kept current.

6.19 The policy identification convention is described below;

6.19.1 Policies are divided into six (6) categories:

6.19.1.1 Consumer Rights and Responsibilities (CRR)

6.19.1.2 Services and Programs (SP)

6.19.1.3 Information Management, Records, and Technology (IMRT)

6.19.1.4 Human Resources (HR)

6.19.1.5 Administrative (A)

6.19.1.6 Fiscal (F)

6.20 The policies will be identified with the letter or letters of the appropriate category, a number to indicate the topic, and a number following a period to indicate the specific policy; the title of the policy will follow. Example: This policy, A –1.1 Policy Development and Review Process is labeled: Administrative (A), the topic (1) is policies, and after the period is the number (1) of the specific policy, which is followed by the title of the policy.

7.0 ATTACHMENTS: N/A

8.0 Implementation of Policy: Each Division agency within the scope of this policy shall implement this policy and may develop specific written procedures as necessary to do so effectively.

EFFECTIVE DATE: 11/20/06
REVIEWED / REVISED DATE: 11/13/07, 08/06/10, 10/2016
SUPERSEDES: #4.066 Policy Development and Review Process
APPROVED BY MHDS ADMINISTRATOR: 08/06/10
APPROVED BY MHDS COMMISSION: 11/17/06, 09/17/10
APPROVED BY THE DPBH COMMISSION ON BEHAVIORAL HEALTH:

POLICY

To provide financial supports to qualified families in accordance with NRS 435.365 and NAC 435.395 to 435.430 for the purpose of supporting the family unit and sustaining natural support networks thereby reducing risk of out of home placement. This financial assistance is intended to be used to offset expenses necessary to meet specialized needs of individuals served by Developmental Services.

PURPOSE

To provide a clear understanding of the Family Preservation Program (FPP) and its objectives to families and agency staff, and to provide information on the eligibility criteria, application process, reporting responsibilities, and the appeals process.

DEFINITIONS

Individual: the person determined eligible for regional center services.

Head of Household: Households designated person to be the recipient of the FPP stipend and the responsible person for completion of the FPP application and supporting documentation.

Household: everyone (grandparents, relatives, significant others and any other individuals who are residing in the family home) who contribute to the household income.

Total family gross household income: the income of everyone (family members, grandparents, and other relatives living in the home, significant others and any other individuals residing in the home) who contributes to the family income.

Parent or relative: the biological parent, relative, legal adoptive parent, or legal guardian of such person (NAC 435.395).

FPP supplement: the money provided to the eligible family by the state.

Severe and profound intellectual disability: evidenced by obtaining scores approximately four or more standard deviations below the mean on accepted methods for assessing intellectual capacity and adaptive functioning with onset before age 18 years ([e.g., standard scores below 40 on measures of intellectual and adaptive functioning for instruments normed having a mean of 100 and standard deviation of 15)., an IQ score of approximately 20-25 to 35-40 (Severe) or an IQ level below 20 or 25 (Profound); standard scores below 40 on measures of adaptive functioning]. For a child under 6 years of age, the child has developmental delays and requires support equivalent to a person with severe or profound intellectual disability.

REFERENCES

NAC 435.395 - 435.430

NRS 435.365

PROCEDURE

A. PROGRAM OBJECTIVES

1. Individual, family circumstances and choices will be the framework in determining the appropriate type of services(s) or support(s) which can best meet the goals of the family.

2. Services provided will be in accordance with desired outcomes, utilizing the least restrictive alternatives, and provided in community-based, integrated environments.

B. **PROGRAM**

1. Relatives with severe or profound intellectual disability; or
2. Children, under the age of six, who have documented developmental delays requiring support equivalent to the support required by a person with severe or profound intellectual disability
   a. The assistance is provided in addition to other community resources available. All eligible families receive a set monthly payment that is established by legislative appropriation each fiscal year. If the number of eligible families exceeds the legislatively approved appropriation, a wait list of families is created
3. Some examples of how the assistance might be used to support the family's efforts to maintain the individual in the home include the following
   a. Medical supports and specialized supplies or equipment (i.e., medical tests, wheelchairs, walkers, special diets, clothing, etc.) that enhance the individual's health and safety and are not provided by Medicaid, health insurance or other benefit;
   b. Transportation services that enhance participation and interaction with the community;
   c. Respite care;
   d. General income supplementation for families to improve their economic resources to help relieve financial stress (i.e. rent, food, utilities, etc.).

C. **ELIGIBILITY**

1. Eligibility for FPP will be determined as outlined in NRS 435.365 and NAC 435.410 and within the parameters established below:
   a. The individual with an intellectual disability must be cared for by a parent or relative with whom they live.
   b. The individual is a legal resident of Nevada and the United States. The applicant (Head of Household) is a legal resident of Nevada and the United States.
   c. Neither the individual nor the parent or other relative with whom they live is reasonably able to pay for his/her care and support.
   d. The total family gross household income is less than the current 300% of Federal Poverty Guidelines. This includes earned and unearned income excluding the individual's Supplemental Security Income (SSI). SSI benefits received by other members of the household are not excluded.
   e. The individual is not participating in the Developmental Services Shared Living Program, receiving supported living services in the home and their paid support staff is a family member living in the same household, or receiving supported living services outside of the family home (Ex. 24 hour supported living, intermittent supported living in own apartment/home).

f. The individual meets the diagnostic conditions for severe or profound intellectual disability as outlined in NRS 435.365 and NAC 435.400.

g. The individual is provided with adequate care by the parent or relative in accordance with the Person Centered Plan and the care includes but is not limited to, personal health and safety, education, and environmental health.

2. If, at any time, a family's income exceeds the current 300% of Poverty Guidelines; the individual is no longer eligible to receive the FPP supplement. The applicant/Head of Household is responsible to inform the Regional Center immediately of any changes in the family's income when and if such changes occur. Failure to notify the Regional Center timely may result in the establishment of a payback agreement with the family to return any funds to the state that were provided when ineligibility was established.

3. If a wait list for FPP exists; individuals will be given the FPP supplement as funds become available. Individuals on the wait list will be prioritized in the following order:

   a. The date of application will determine who is served first. If there is more than one family with the same priority of need and date of application, the statewide manager will determine who will receive services first based upon a review of the application information.

D. OTHER BENEFITS

1. The FPP applicant/Head of Household must apply for all other welfare/assistance programs, as appropriate, to meet their relative's needs, i.e. SSI, RSDI, Medicaid, etc. Verification of application and receipt or denial of benefits must be provided to the Service Coordinator at the time of submission of the FPP application.

2. The Service Coordinator will assist in the identification of all applicable benefit programs.

E. APPLICATION PROCESS

1. Applicants/Heads of Household must contact the Intake Department of the Regional Center and apply for Regional Center services. All applicants for Developmental Services are screened at intake for eligibility for the FPP. The DS Intake Worker will make a recommendation for the FPP if the applicant appears to meet eligibility requirements.

2. The individual must be determined eligible for Regional Center services. Once eligible, the individual will be assigned a Service Coordinator. The Service Coordinator will assist with the application to the FPP.

3. A FPP application will be completed by the applicant/Head of Household with the assistance of the Service Coordinator, if needed, and submitted by the Service Coordinator to the statewide FPP coordinator within 5 work days of receipt of all documentation required.

   a. The applicant/Head of Household is responsible for providing all required documentation in accordance with Attachment A: Family Preservation Program Application for Assistance.

   b. The applicant/Head of Household is responsible for completion of the Vendor Registration Form obtained from the Regional Center Service Coordinator. This form needs to be returned to the Service Coordinator for processing with the application.

F. ELIGIBILITY DETERMINATION PROCESS

1. The FPP application is received by the FPP office and the eligibility or ineligibility determination is made. If the application is incomplete, it is returned to the Service Coordinator for completion and resubmission. All new FPP applications, annual redetermination applications with updated diagnostic evaluations, and applications for children turning six years of age are reviewed by the ADSD FPP Psychologist for verification of diagnostic eligibility. Additionally, the ADSD FPP Psychologist will review all FPP applications and redeterminations if there are questions concerning the diagnosis of severe/profound intellectual disability (or developmental delay for children under 6).
   a. The FPP Manager or designee will notify the Head of Household and Service Coordinator of the eligibility decision.
   b. Applicants determined eligible for FPP will receive retroactive assistance from the first day of the month after the date the completed application was received.

G. VERIFICATION OF SOCIAL SECURITY NUMBERS

1. The Service Coordinator is initially responsible for verifying the social security number of the Head of Household on the Vendor Registration Form. "Head of Household" is determined by the family when submitting the FPP Application for Assistance and the Vendor Registration Form to the Service Coordinator. The Service Coordinator must visually inspect the social security card and the number entered onto the Vendor Registration Form to ensure the correct number has been entered. No copies are to be made of social security cards.
2. The FPP Program Officer I is responsible for the final verification of social security numbers of the applicant/Head of Household by looking up the number provided on the Vendor Registration Form via the Social Security Number Verification System with the Social Security Administration and it's submission to the Controller's Office.
   a. The Service Coordinator is responsible for verifying eligibility information at the time of the quarterly review.
   b. Once notified of any changes the Service Coordinator is responsible for notifying the Program Officer I of any changes in FPP recipient information such as financial status, benefit status, lack of responsiveness or follow-through by the family/guardian to service delivery identified in the Person Centered Plan (PCP), identification of health and safety concerns of the individual, and address changes. Please see section III (A) of this policy for further clarification.
   c. The Service Coordinator is responsible for ensuring that the applicant/Head of Household is informed of the requirement to complete a Vendor Informational Update form and submit it as changes occur, and that the submission is forwarded to the Program Officer I.
   d. The FPP Program Officer I is responsible for submission of the updated form to the Controller's Office.

H. REPORTING REQUIREMENTS

1. Applicant/Head of Household reporting requirements are noted in the FPP Application for Assistance. This document is signed by the family and specifically includes the

requirement and affirmation to follow Reporting Responsibilities for the Family Preservation Program.

a. Applicant/Head of Household Responsibility:

1) The applicant/Head of Household is required to notify the Service Coordinator of any changes in residency, household composition, income, other benefits received, and things of value owned by the family in accordance with NAC 435.395 to 435.430. Failure by the applicant/Head of Household to report changes may result in termination of the FPP supplement.

b. Service Coordinator Responsibility

1) To ensure Reporting Responsibilities for the Family Preservation Program is given to the applicant/ Head of Household at the time of application to the program and at redeterminations.

2) To notify the FPP Office if the individual receiving services enters into a Shared Living Arrangement with the family they are living with or if the family member becomes a direct support staff for their family member.

3) Submit the Family Preservation Program Change Form within 5 working days when notified of any changes in status to income, household composition, diagnoses, and changes or termination of services.

I. PLANNING

1. The assigned Service Coordinator will work with the individual, applicant/Head of Household, family and support team to develop a Person Centered Plan (PCP). The support team consists of people identified by the individual, applicant/Head of Household, family, Regional Center Service Coordinator and other professionals determined necessary to the planning process.
2. The PCP is written to reflect the receipt of the FPP supplement and any other benefits and addresses support needs identified by the team and the individual related to personal health and safety, education, environmental health and use of financial assistance to enhance the general welfare of the individual.

J. PAYMENT

1. FPP supplement checks will be issued by the State Controller's Office to the applicant/Head of Household.
   a. The Controller's Office will be notified by ADSD to stop payment on any FPP supplement checks not cashed within 90 days of issuance.
   b. If an overpayment occurs, subsequent monthly payments will be reduced until the amount of overpayment is recovered.
   c. If FPP eligibility is terminated and an overpayment has occurred, the recipient of the overpayment will reimburse the regional center within 60 days of notification.

K. REDETERMINATION

1. An annual re-determination of FPP eligibility is required and will be completed at the annual PCP meeting.

a. The applicant/Head of Household is responsible to submit updated information to the Service Coordinator within 15 working days of the date of the annual PCP meeting.

b. The Service Coordinator is responsible to notify the FPP Office Program Officer of any updated information no later than 30 days after the annual PCP meeting month. This includes but is not limited to:

c. Updated financial information provided by the applicant/Head of Household, family;

1) Applicant/Head of Household changes and new Vendor Registration Form if changed;

2) Updated Social Assessment;

3) Updated psychological assessment or psychoeducational assessment, if completed;

4) For children, a MDT summary and statement of eligibility from school every 3 years;

5) Current address, phone number and other relevant contact information.

L. TERMINATION

1. FPP benefits will be terminated if any of the following occur:
   a. Provision of false or misleading statements;
   b. Misrepresentation of facts;
   c. Concealing or withholding facts to establish or maintain program eligibility; or
   d. Failure to report changes in circumstances.
2. Upon report of the death of the individual receiving a FPP supplement, the applicant/Head of Household is eligible to receive one additional month of FPP supplement.

M. DENIAL AND APPEAL

1. The FPP Manager will notify all applicants or recipients in writing if denied or determined ineligible for the Family Preservation Program. Decisions may be appealed by submitting a written request for review to the Regional Center Manager or designee within 15 working days of the date of the denial.
   a. A review of the denial/ineligibility will be conducted by the Regional Center Agency Manager or designee within 30 calendar days of receipt of the written request for review.
   b. Further appeal may be made in writing by the applicant or recipient to the ADSD Administrator or designee. The appeal must be filed within 15 days of the applicant's or recipient's receipt of the notice of the decision by the Regional Agency Manager or designee
2. According to NRS 435.365 (3): "The decision of the Division regarding eligibility for assistance or the amount of assistance to be provided is a final administrative decision."

ATTACHMENTS (CLICK BELOW)

CHAPTER 36 FORMS

Attachment A - Application for Family Preservation Program

Attachment B - Reporting Responsibilities for Family Preservation Program Benefit Recipients

Attachment C - Family Preservation Program Change Form

Approved By		
Title	Signature	Date
Deputy Administrator	Carla Fong	10/25/16
Division Administrator or Designee		

Document History

Revision	Date	Change
1	6/20/2016	Reformatting, spelling corrections and verbiage

POLICY

Respite funds allows individuals/families the opportunity to receive financial assistance to self-direct the purchase of respite services to support individuals in their most natural family environment and allow caregivers respite from daily direct caregiving activities

PURPOSE

The policy provides guidance and clarification on program requirements. Respite Care is planned care that is provided to a child or adult who has an open case with a Regional Center and meets specified regional center eligibility requirements, in order to provide temporary relief to primary caregivers who are providing care for the child or adult. The Respite Program is intended to assist the person served to be maintained in their natural or surrogate family home. Services include, but are not limited to, supervision in the home, allied therapy services in the community, organized community camps, and community vendors providing care and other supports. The respite program is intended to supplement natural supports, family strengths, and community resources available to the family. This service is not intended to replace natural supports. This service is not to be used to purchase items or medications.

PROCEDURE

A. PROCESS

1. The financial eligibility for Respite is based on applicable federal poverty guidelines per household.
2. The family is responsible to submit annual required financial documentation per regional center guidelines. This will require submission of their most recent federal income tax return or a signed statement indicating that a tax return was not filed.
3. The regional center ASO and Agency Manager will manage the budget and waitlist. The monthly allocation will be determined by the legislatively approved amount of funding in this budget category and the number of consumers utilizing respite the previous fiscal year, taking into consideration anticipated consumer growth or decline. The monthly allocation will be the same amount statewide. For minor children living in rural counties, approval through the county of residence of the custodial parent is needed prior to offering the service through the regional center.
4. Individuals who receive non-organizational provided Shared Living supports (SLA), (i.e., regional center providers not under an organizational provider), and intermittent SLA services are eligible for respite services. Individuals who receive services from ATAP are eligible for respite services.
5. Individuals receiving 24 hour ISLA or SLA services or a self-directed service are not eligible to access respite funding. Individuals who are currently in DCFS custody are not eligible to receive respite services through Developmental Services.
6. Respite Services may have a waitlist due to budgetary constraints. If there is a waitlist for respite services, the Service Coordinator will submit a service request to their supervisor to add the person to the waitlist. Waitlist determinations are based on priority of need and length of wait and/or financial availability. Respite funding can be discontinued at any time based on availability of state funding or if funding is not being used for the intended purpose.

7. Families will be notified by their assigned Service Coordinator when the service is approved. Individuals/families will be required to complete the Annual Respite Agreement and the Respite Packet. It is the responsibility of the family to complete and return the Respite Packet by the annual deadline. All forms and information included must be completed prior to review and approval or disapproval of the packet.
8. All Providers must be at least 18 years of age. Parents or guardians are responsible to ensure that those persons designated as providers in this program meet age requirement and are able to perform the respite service with due care and diligence.
9. Providers of respite cannot be the biological or adoptive parent(s), step-parent, foster parent(s), guardian, spouse, or primary caregiver(s).
10. Providers of the respite program must be eligible for payment through the State of Nevada Vendor program before services can be funded. It is the caregiver's responsibility to ensure that the provider W-9 paperwork is filed with the regional center respite program.
11. It is the responsibility of the family to complete and return the Respite Packet to include the Family Respite Agreement, State of Nevada W-9 and provide identification.
12. Individual's respite needs will be identified in the Person Centered Plan.
13. The parent or caregiver of the person served in the respite program is responsible for negotiating the rate of pay to providers and will sign all invoices to confirm that the service was provided.
14. Unless otherwise authorized by the Agency Manager, or designee, all respite allocations must be used on a monthly basis unless the individual/family submits a written request and receives approval from the Agency Manager or designee for alternate funding arrangements within the fiscal year. Families who do not use respite funds for two consecutive months may have their Respite Agreement terminated unless a pre-approved request for alternate funding is in place –or if special circumstances regarding the nonuse exist.
15. A parent/caregiver must request in writing the option to save their respite allocation for an identified period to pay for an organized vacation camp, evidenced-based therapeutic and/or behavioral program. This request must be submitted to the Service Coordinator and pre-approved by the Agency Manager or designee in advance.
16. Respite Services must be provided and paid for within the same fiscal year that service occurred. Billing submitted after the 10th of each month will be considered late billing and may be denied payment.
17. The parent or caregiver of the person served will be financially responsible for any funds utilized above and beyond the respite allocation or if respite services are provided prior to regional center approval.

B. **BILLING OF SERVICES:**

1. Providers are responsible to have the appropriate billing paperwork completed and signed by the parent/caregiver confirming the respite hours were provided. Parents/caregivers are responsible for ensuring that invoices are forwarded to the regional center for processing and payment.
2. Invoices received 60 days after the date of service may **NOT** be reimbursed.

3. Invoice dates cannot precede the signature dates provided on the Family Respite Agreement, which is the contract binding the respite service.
4. Invoices must be submitted to the regional center business office by the 10th of the following month that the services are provided in order to be processed that month. Invoices received after this time frame may result in Respite Service Administration:

C. APPEALS PROCESS:

1. The parties mutually agree that the Agreement and/or Vendor status may be terminated upon thirty (30) days prior written notice by any party to the other. In the event of such termination, the Provider agrees to turn over to the state agency any and all data, information, recommendations, materials and reports collected or prepared by them, pertaining to the service agreed to be provided to the Agency. The parties acknowledge that funding under this agreement is expressly conditional on the availability of the State, County and Federal funding for these services.

ATTACHMENTS (CLICK BELOW)

CHAPTER 36 FORMS

Attachment A – Income Eligibility Application for Services – English

Income Eligibility Application for Services – Spanish

Attachment B – Respite Letter – English

Respite Letter – Spanish

Attachment C – Respite Reimbursement Request Form

Attachment D – Respite Distribution Request

Attachment E – Respite Eligibility Letter – English

Respite Eligibility Letter – Spanish

Attachment F – Income Tax Declaration – English

Income Tax Declaration – Spanish

Attachment G – Instructions for Income Eligibility Information – English

Instructions for Income Eligibility Information – Spanish

Attachment H – Reporting Responsibilities for Income Eligibility – English

Reporting Responsibilities for Income Eligibility – Spanish

Attachment I – Statement Regarding Unemployment – English

Statement Regarding Unemployment – Spanish

Attachment J – Things to Remember – English

Things to Remember – Spanish

Attachment K – Unearned Income – English

Unearned Income – Spanish

Attachment L – Direct Deposit Authorization – English

Direct Deposit Authorization – Spanish

Attachment M – Aging and Disability Services Division Family Respite Agreement

Attachment N – Samples

Attachment O – State of Nevada Vendor Registration

Approved By		
Title	Signature	Date
Deputy Administrator	Cara Tod	5/26/16
Division Administrator or Designee	Janet Rumer	5/26/16

Document History		
Revision	Date	Change

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
AGING AND DISABILITY SERVICES DIVISION				
2016 POLICY MANUAL				
POLICY #	REVISED	TITLE	EFFECTIVE DATE	PAGE
37 - 1		**Durable Power of Attorney for Health Care Decisions**	Upon Approval	**1 of 2**

POLICY

Individuals supported by Developmental Services' Regional Centers will have access to information regarding a durable power of attorney for health care decisions as outlined in NRS 162A.

PURPOSE

To assure that individuals supported by Developmental Services receive optimum health care and that they are supported in making health care decisions.

REFERENCES

NRS 162A

PROCEDURE

A. REGIONAL CENTER STAFF

1. Staff, as appropriate, will provide information on NRS 162A to individuals supported regarding a durable power of attorney for health care decisions. Circumstances under which this may occur include, but are not limited to, discussion of medical concerns and team meetings. Information provided will include specific information regarding NRS 162A, including, but not limited to, the role of the agent, how to create a durable power of attorney, and the circumstances when the durable power of attorney would be used.
2. If the individual is interested, staff will provide a copy of Attachment A, "Durable Power of Attorney for Health Care Decisions". Staff will review this attachment with the individual as appropriate.
3. Staff employed by the Regional Center and staff employed by contract Providers of the Regional Centers may not act as an agent for the individual, unless the staff has a relationship with the individual (i.e., spouse, legal guardian or next of kin of the individual) outside of their professional role. In circumstances where an individual wishes to have a Regional Center staff or Provider staff act as their agent, the relationship must first be approved by the Agency/Program Manager or designee.
4. State staff and Provider staff will neither encourage or discourage the use of the durable power of attorney.
5. When a durable power of attorney is completed, Regional Center will request a copy and will review at least annually with the individual to assure that the information in the document has not changed. Regional Center Service Coordinators will assure that applicable Providers also have a copy of this document.

ATTACHMENTS (CLICK BELOW)

Attachment A - Durable Power of Attorney for Health Care Decisions

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
AGING AND DISABILITY SERVICES DIVISION				
2016 POLICY MANUAL				
POLICY #	**REVISED**	**TITLE**	**EFFECTIVE DATE**	**PAGE**
37 - 1		**Durable Power of Attorney for Health Care Decisions**	Upon Approval	**1 of 2**

Approved By		
Title	Signature	Date
Deputy Administrator		4/27/16
Division Administrator or Designee		4/28/16

Document History		
Revision	Date	Change

POLICY

It is the policy of Developmental Services (DS) Regional Centers that each individual residing in a supported living arrangement,SLA (which includes Intermittent Supported Living Arrangements, Host Homes, and 24 hour Supported Living Arrangements) receive standard and customary medical support services, to promote and facilitate best possible health, and to ensure that each individual receiving support (and as applicable their guardian) is aware of treatments, services and provider choices.

PURPOSE

It is the purpose of this policy to provide clear guidelines for the provision of healthcare and medication support for individuals served by DS Regional Centers in supported living arrangements (SLA).

PROCEDURE

A. ROUTINE MEDICAL CARE FOR INDIVIDUALS IN SUPPORTED LIVING ARRANGEMENTS

1. Each individual shall have access to one or more community health care providers, for both routine and emergency care. Current information on involved healthcare providers will be shared with the Regional Center Service Coordinator (SC) and Community Providers of Supported Living Arrangement (SLA) staff, to ensure that each individual receives prompt medical treatment for illness or accident.
2. SLA providers will ensure that health care providers (to include physicians, specialists, all licensed prescribers, pharmacists, dieticians, therapists, and nurses) have adequate and current information available at the time of an appointment or consult to facilitate effective treatment decisions. This would include a list of all current medications, allergies, diagnoses, health history and other symptoms or conditions (i.e. dietary, behavioral etc.).
3. As recommended by attending health care providers and/or Individual Support Plan (ISP) team, SLA providers shall schedule medical, dental, vision, nutrition, therapies, mental health and specialist appointments, as well as arrange transportation to those appointments as applicable and recommended by the ISP team. For individuals who repeatedly refuse to attend appointments, the team will determine if the refusal of service is placing the individual at imminent risk and will take appropriate action to protect against harm or injury. SLA providers will follow reporting protocol as defined in DS Regional Center's policies on Individual's Rights. The SLA provider will notify the healthcare provider and ISP team of the individual's refusal of recommended appointments. The SC will notify the supervisor immediately and the Agency Manager and/or Clinical Program Manager within 48 hours if the individual's refusal of treatment is contrary to the recommendation of the health care provider and could pose imminent risk to the individual's health and welfare. Regional Center administration will assist the ISP team in determining an appropriate course of action.
4. The frequency of annual physicals and/or nursing assessments will be determined by each individual's support team. This determination will be based on the individual's current health status and health history. Individual and family history information will be updated annually with assistance from the SLA provider prior to the annual physical and presented to the attending physician at the time of the physical for their review. The annual physical form is to be completed at the time of the physical examination. The physician's comprehensive documentation of the physical examination may be accepted in lieu of completion of

Regional Center's Annual Physical Form. The SLA provider will submit a copy to the Regional Center SC within 2 business days of the appointment and the SLA provider will retain a copy. For individuals in ISLA and Host Home living arrangements a copy shall be available in the individuals' records at their homes. Regional Center SC will be responsible for submitting referrals to DS community nurses for recommended nursing assessments and consults. The completed nursing assessment/consult report will be forwarded to the Regional Center Service Coordinator who within three business days of receiving will: review; file the original in the individual's record; send a copy to the SLA provider and, as applicable, JDT provider for review and inclusion into the individual's home and Jobs and Day Training (JDT) record. As applicable the ISP team will use the assessment in facilitating development of support plans/protocols related to recommendations.

5. Prior to each health care provider appointment, the SLA provider will complete the designated sections of the Medical Visit form with accurate and current information. Per DS Record Requirements 12 months of documents will be maintained in the home files.
6. Preventative and maintenance health screenings will be completed upon the health care provider's recommendations, as well as recommendations from ISP team members reviewing risk factors.

   Please refer to http://www.mhqp.org/guidelines/preventivePDF/MHQP_AdultPrevCareGuidelines.pdf for current preventive health screening recommendations.
7. The SLA provider will ensure all signed and dated licensed prescriber orders/prescriptions are either faxed or delivered to the pharmacy immediately upon receipt. Copies of all routine and PRN medications and treatment orders will be at the individual's residence prior to administration of a new medication, dosage change, or change in treatment orders for individuals in 24 hour Intensive Supported Living Arrangement (ISLA), Host Homes, as well as in Intermittent SLA residences for individuals who require support with medication administration as addressed in the ISP and support plans. The individual's home record will also contain side-effect sheets for all medications currently prescribed to the individual.
8. The SLA provider will notify ISP team members (Regional Center SC, guardian, JDT provider, family as applicable, etc.) of all medication and/or treatment orders, recommendations and changes including any health care precautions within 2 business days.
9. Individuals' immunization records will be part of the Regional Center permanent file and will be maintained in the individuals' files with the provider. In the event that records are not available, historical information from families/guardians/care providers will be used as guidelines for health care planning.
10. The SLA provider will complete assessments of health and safety needs, and as directed by the ISP team's recommendations, will develop health support plans and train staff prior to initiation of services. In cases of extreme emergency where immediate services are required to protect health and welfare, assessments shall be completed as soon as possible after initiation of services with additional precautions and safety measures taken until assessments and appropriate plans are completed and staff training can be provided.

B. LICENSED PRESCRIBER ORDERS

1. All licensed prescribers' orders shall be followed unless the individual, guardian, or team has expressed concerns with the treatment recommendation. Should this occur the team

members (including the health care provider) will address and thoroughly document the final outcome in ISP and case notes.

2. The team will act immediately when there is a health care provider's recommendation for treatment. The SLA provider and ISP team members will seriously and respectfully consider the individual's choices and desire to refuse service or treatment. The agency advocates for individuals' fundamental rights to make choices. Should individuals' choices be contrary to the ISP team's recommendations, the team will determine if the refusal of treatment and/or service is placing the individual at imminent risk or posing a safety risk to others and will take appropriate action to protect against harm or injury. SLA provider will follow reporting protocol as defined in Regional Center's Incident Reporting policy. The SLA provider will notify the healthcare provider and ISP team of the individual's refusals of recommended treatment. The Regional Center SC will notify the assigned supervisor immediately and the Clinical Program Manager and, as applicable, Agency Manager within 48 hours if the individual's refusal of treatment is contrary to the recommendation of the health care provider and ISP team and could pose imminent risk to the individual's health and welfare. The Regional Center administration team will assist the ISP team in determining an appropriate course of action.
3. The SLA provider will notify the health care provider of the individual's refusal of the recommended treatment, to include general refusal or patterns of refusals of medications. The licensed prescriber will then make the determination for appropriate course of action including admission to a hospital for treatment should it be deemed that the individual's health and safety are at risk.
4. In the absence of expressed and informed consent, a licensed and qualified physician may render emergency medical care or treatment to any individual who has been injured in an accident or who is suffering from an acute illness, disease, or condition, if within a reasonable degree of medical certainty, delay in the initiation of emergency medical care or treatment would endanger the health of the individual per NRS 433.484.
5. As applicable, orders for health care monitoring related to chronic health conditions (Ex. Obesity, Diabetes, Hypertension, Chronic Constipation, Seizure Disorder) or concerns (i.e. a specific dietary plan with tracking of daily intake; [1800 calorie ADA diet], blood pressure, glucose levels, seizure activity, bowel tracking , etc.) will have parameters for staff to follow set forth by the provider of healthcare or ISP team recommendations and clearly documented in the Habilitation Plan(DS-ISP-15 (A)) or the Service Plan Protective Oversight and Supervision (DS-ISP-15 (B)) with data collected to determine effectiveness. Regional Center SC and SLA Staff are responsible to ensure support plans are developed for all Chronic Conditions and obtain parameters from appropriate provider(s) of healthcare in the event they have not been clearly documented by the licensed prescriber with review and approval by a licensed prescriber. (Resources may include pharmacists, provider-contracted nurses, DS community nurses, dietician, etc.)
6. Medications will be administered only to the individual for whom they are prescribed.
7. The SLA provider will establish agency standard medication administration times for orders written as "daily, a.m., p.m., H.S., B.I.D, T.I.D, and Q.I.D." which will be shared with treating healthcare providers. As applicable an order will be needed for administrations deviating from the SLA provider's standard times.

If orders/prescriptions note approval for generic substitutions both the generic and brand names for the medication shall be documented on the Medical Administration Record (MAR).

As applicable, prescriptions/orders shall include directions for altering a medication's original form (cutting, crushing, placing in food substance etc.) prior to providing support or administering the medication. No deviation from an order is allowed. All individuals in ISLA, Host Home, and Individuals in Intermittent SLA who require support with medication administration, will have orders/standing orders from the licensed prescriber for each over the counter medication used (i.e. pain relief such as Tylenol, Ibuprofen; gastric distress such as Pepto Bismol, etc.). All standing orders will include the symptoms and parameters for use and will be submitted to the pharmacy. (Note: Use per package directions is acceptable if the individual is able to self-report symptoms and indicate their request for a medication.) For individuals who are unable to self-identify, effectively communicate, and/or exhibit no observable symptoms indicating the need for a PRN medication a support plan must be developed to guide the SLA direct support staff in recognizing the individual's objective identifiers or symptoms of pain or discomfort.

8. Medications will be removed from original containers with minimal handling.
9. The use of medication minders is prohibited unless filled per the NRS 454.213, "Dispensing of Dangerous Drugs" and DS Policy 1.4.
10. Provider staff may not administer or support an individual in taking medication or receiving treatments (other than support by staff certified in CPR/Basic First Aid) unless ordered by a licensed prescriber. Once ordered by the physician or licensed prescriber the medication is given according to the licensed prescriber's directions and a record of each dose is maintained on the individual's MAR. Changes in medication dosage and new medication orders will be acted upon within 24 hours or within time frames as directed by the prescribing health care professional.
11. Administration of As Needed (PRN) Medications
    a. Prior to administering any PRN medication, the provider will ensure the following:
        1) A provider of health care and/or the ISP team, in agreement with the licensed prescriber, has identified the ability of the individual to self-identify the need to receive a medication;
        2) If the individual is unable to self-identify the need to receive a medication, the ISP team will develop a support plan outlining objective identifiers for which the medications can be administered;
        3) Objective identifiers will be included in the individual's support plan related to treatment of chronic conditions and will include data collection for monitoring and tracking of symptoms as applicable;
        4) The SLA staff member administering the medication will document the date and time the PRN medication was taken, the dosage taken, the observed identifiers/reason the medication was given and note the individual's response regarding effectiveness of the medication on the back of the Medication Administration Record (MAR); and
        5) For individuals who are able to self-identify the need for PRN medications, one support plan may be developed for all PRN Standing Order Medications for acute exacerbations of general medical conditions. If unable to self - identify the need for a PRN/OTC medication, the ISP team will document in the individual's

support plan the objective identifiers an individual may exhibit for any PRN/OTC ordered.

C. MEDICATION SUPPORT

1. All individuals who are to receive SLA services (24 hour, Intermittent SLA and Host Home) will have an initial Medication Administration Assessment (DS- ASS-01) prior to receiving services or supports from the SLA Provider, to ensure that the proper level of support is available and in place at the time of entry into services. The ISP team will review the assessment at least annually and determine if an update is warranted based on changing condition or status. This team discussion and review will be documented in the ISP.
2. Only staff currently certified in Medication Administration from a DS approved program will be authorized to administer medications per NAC 435.675. Individuals requiring this level of support must have "Medical Clearance by the Provider of Healthcare" (DS-LC-01) and "Authorization for Medication Administration by Certified Direct Support Staff" (DS-LC-02) signed, dated and placed in their files annually. Individuals who are assessed to be capable of self-administration of medication will be reviewed annually and the individual's guardian will sign an acknowledgment.
3. The SLA provider will ensure that individuals maintain an adequate supply of medication on hand to prevent delay or disruption in administration. Refills of medication will be called into the pharmacy no less than 7 days prior to end of supply. SLA staff will continue to follow up with pharmacy prior to the end of the supply if the medication is not received and will document all efforts to ensure the refill is received in a timely manner. If an individual has "zero refills" the SLA provider will notify the licensed prescriber no less than 30 days prior to the end of the current supply to determine if an appointment is necessary to ensure timely refill. SLA Provider will document all efforts to contact the licensed prescriber per their agency's policy.
4. Medications must be secured and stored in a manner that is deemed safe for the individual's assessed skill level and, as applicable, the skill levels of the individual's house mates, as determined through completion of the Medication Administration Assessment Tool (DS-ASS-01) and approved by the ISP Team. All containers used to store medication will be labeled with the individual's name, to include over the counter medications and med minders as applicable. All controlled substances will be stored in a locked container/ closet/file cabinet when the individual is residing in a 24 hour Supported Living Arrangement or Host Home, no matter the skill of the individual or housemates.
    a. Direct Support Staff Certified in Medication Administration may provide supervision and guidance with the use of medication minders but may not fill a med-minder for the individual.
5. Medications requiring refrigeration will be stored in a secured labeled container separate from food or beverage. Depending on skill level of individual and as applicable, the housemates, this container may be required to be locked. Controlled medications requiring refrigeration will be in a locked container.
6. Otic (ear), Optic (eye), Nasal, Liquid, and Topical (applied to the skin) medications will be stored in a container labeled with the individual's name and kept separate from oral tablet/capsule medications and suppositories.

7. Unused medication shall be returned to the pharmacy or destroyed per SLA provider policy and documented in the individual's home record. ***Please note "Medication Arrival and Removal Logs" must be maintained as stipulated in policy DS 1.4.***
8. Medications that are considered controlled substances (per DEA Schedule), including those in liquid form, are to be counted by support staff **responsible** for medication administrations at each change of shift and when administered. All counts must be verified by a witness when possible. For individuals receiving Intermittent SLA services, the Individual Support Team (ISP), will address and document any prescriptions for controlled substances and determine a procedure/plan for protective oversight based on the individual's support needs. Mishandling of medications that are considered controlled substances will be reported per Policy 810 Incident Reporting.
9. SLA staff will be trained in the standard documentation procedures for all medications and medication errors, to include single line strike through on all changes, labeled with the date and the staff's initials making the change. All medication errors, PRN, or variances from the routine medication process, including medications administered outside of the residence (JDT, home visit, recreation event, etc.), will be circled on the front of the MAR and noted on the back of the MAR, as to what occurred, who was contacted and specific outcome. For occurrences of medication dose changes mid-month in which new bubble/dose packs are not dispensed by the pharmacy, SLA staff will write clearly with black marker on the top of the bubble pack to the side of the original label "Order Change See MAR" date and initial. (Please note that the original label may not be altered.)
10. Medication errors require notification to a licensed prescriber, pharmacist or nurse. An incident report and Denial of Rights form must be completed and submitted to the Regional Center SC within 1 business day of discovery of the error. For serious medication errors (wrong person, wrong dose, wrong medication, missed medication over 24 hours and failure to administer new prescription within 24 hours or as directed by licensed prescriber) the licensed prescriber must be notified.
11. SLA provider agencies will only provide psychopharmacological medications on a PRN (as needed) basis with written informed consent. The order must include symptom(s)/objective identifiers for which the medication is to be used, and include specific parameters for administration which will be documented in the individual's health service habilitation/service plan. An ISP team meeting will be held and a support plan will be developed if the PRN medication is determined to be needed for an extended period of time and not just a one-time use. Due process will be followed. A Denial of Rights form will be completed and filed with the Quality Assurance Department for administration of a psychotropic medication without completion of due process.
12. SLA provider will ensure that standing order medications are readily available to the individuals on the onset of symptoms. Medications for pain relief must be maintained in the home for immediate administration. SLA providers will ensure standing order medications are immediately available/on hand and administered promptly for those individuals who have been assessed to need these medications on a frequent or routine basis.

D. MEDICATIONS GIVEN OR MONITORED OUTSIDE OF PRIMARY RESIDENCE

1. SLA Provider will ensure the individual has the proper amount of medications sent for all family home visits, work, camp, vacations, etc. and will ensure proper documentation on MAR.

2. SLA Provider is responsible for supporting the individual with taking the medications outside of their residence in the following way.

   a. When an individual leaves the residence for a short period of time during which only one dose of medication is needed the SLA staff may give the medications to the individual or a responsible/authorized person (i.e. SLA staff, family member) in a secured envelope (or similar container) labeled with the individual's name, name of medication(s) and instructions for administering the dose.

      If the individual is to be gone for more than one dosage period the SLA Provider may:

      1) Give the full prescription container to the individual or responsible/authorized person OR
      2) Have the pharmacy either fill a separate prescription or separate the existing prescription into bottles/bubble packs OR

         The legal guardian, or individual with the assistance/guidance of a staff certified in medication administration, may fill the medication minder.

3. SLA provider will ensure that family members, JDT providers, etc., assisting with medication supports are aware of medication administration times, side-effects of medication and purpose of medication to promote adequate monitoring and support in medication administration outside of the individual's residence.
4. SLA provider will have a system (procedure) for accountability for medications taken outside of the residence.

E. MEDICATION AND TRANSFERS FROM ONE HOME TO ANOTHER

1. An individual's current medication will accompany him/her to their new home. This will include copies of current prescriptions indicating times, dosages, prescribing physician or licensed prescriber and copies of side-effects sheets for all medications. All other pertinent facts will be provided to the new service provider by the previous SLA provider, treatment facility, and/or family member. Arrangements shall be made to provide sufficient medication going with the individual to his/her new home to prevent any disruptions in the medication administrations.

F. SUPPORT TO INDIVIDUALS WHO USE OXYGEN

2. SLA Providers to ensure that the following conditions are met if oxygen equipment is in use:

   a. It is suggested the SLA provider notify the local fire jurisdiction that oxygen is in use at the home;

   b. "No Smoking-Oxygen in Use" signs shall be posted in appropriate areas.

   c. Smoking is prohibited where oxygen is in use;

   d. All electrical equipment is checked for defects that may cause sparks;

   e. Oxygen tanks that are not portable are secured either in a stand or to a wall;

   f. Plastic tubing from the nasal cannula (mask) to the oxygen source is long enough to allow the individual movement within his/her home but does not constitute a hazard to the individual or others;

g. Individuals use oxygen from a portable source when they are outside the home;

h. Equipment is operable and receives routine scheduled maintenance (i.e. operating as intended, in good condition, good working order, individual/staff is able to operate it correctly);

i. SLA Provider staff have knowledge and ability to operate and care for the oxygen equipment;

j. Equipment is removed from the home when no longer in use by the individual.

G. MEDICAL EMERGENCIES

1. Community SLA providers are required to have a policy and procedure that addresses emergency medical care. Support staff employed by providers, must be certified in First Aid and CPR within 30 days of hire and prior to working independently with individuals and shall maintain current certification status. SLA provider staff must be knowledgeable of the signs and symptoms of life threatening conditions and the procedures for obtaining emergency medical care in an expeditious manner prior to working alone with individuals. Community providers are required to provide training/ education/ in-services to staff on the agency's emergency medical care policy and procedure at the time of employee orientation and annually thereafter.
2. Emergencies must be attended to immediately and verbally reported to the Regional Center SC, a supervisor, or the Community Services emergency cell phone if applicable in the Regional Center. Voice messages may not be left, refer to DS Regional Center Policies on Incident Reporting.
3. Each SLA setting shall have a well-stocked First Aid Kit to include, but not limited to: CPR mask, bandages, gauze, medical tape, gloves, antibiotic ointment, thermometer, tweezers, cold pack, ace bandage, and alcohol wipes. (SLA services provided in family homes is exempt from this requirement, though encouraged.)
4. The clinical Program Manager and the Agency Manager must be advised within one business day of all serious medical situations in which a physician or licensed prescriber has voiced concerns regarding an individual's competence to give informed consent for urgent medical care and treatment to assist in determining a course of action. However, until the courts make a ruling regarding competency, the individual's signed consent is considered legal. The ISP Team may consider the need for advocacy services (i.e. temporary guardianship) during the interim period per NRS 159.0523. In the absence of express and informed consent, a licensed and qualified physician or licensed prescriber may render emergency medical care or treatment to any individual who has been injured in an accident, or who is suffering from an acute illness, disease, or condition, if, within a reasonable degree of medical certainty, delay in the initiation of emergency medical care or treatment would endanger the health of the individual (per NRS 433.484).
5. SLA providers and Regional Center SC will retain copies of Advanced Directives for individuals' records as applicable.

H. HOSPITALIZATIONS

1. SLA providers shall not authorize a non-emergency surgery or hospitalization without proper advanced notification to the Regional Center SC, and ISP team and without written informed consent of a legally authorized person.

2. All individuals prior to discharge from the hospital (or other institution) will receive an assessment of their current support needs by the SLA provider which will include consult with hospital/facility staff and review of discharge orders. SLA provider will ensure that the individual's needs may be met in the SLA setting prior to accepting the individual's discharge. Additionally, discharge assessments may entail: a review of the medical record by the Regional Center community nurse or SLA Provider contract nurse consultant; case consultation with hospital staff by Regional Center SC; and, as appropriate, Community Services Nurse; a request and review of Pre Admission Screen and Resident Review (PASRR) screening; and the ISP team's review of SLA provider and community resources available to meet identified current needs. In the event that an individual's support needs have changed requiring a higher level of support than is able to be provided in the supported living arrangement, the ISP team will take the appropriate actions to determine and assist in arranging for alternate placement options.

I. MEDICAL CARE FOR INDIVIDIUALS IN SUPPORTED LIVING ARRANGEMENT

1. Each individual will choose, or be supported in choosing, their personal health care providers. The SLA provider and Regional Center Service Coordinator will assess the individuals' level of satisfaction with the health care provider and support change as needed or requested.
2. Each individual will have medical insurance and will be supported to maintain coverage.
3. SLA providers and the Regional Center will maintain information regarding medical/family histories, drug history, and food allergies and ensure all staff working with the individual is apprised of this information and level of support required as appropriate to their role and function.
4. SLA providers will have internal systems and procedures in place to monitor the condition of adaptive equipment, communication devices, glasses, dentures, hearing aids, etc., identifying needs for repair/replacement and are completed timely and efficiently
5. ISP teams will ensure that chronic health conditions have specific support plans for staff to follow including prevention strategies, monitoring of symptoms; and administration of prescribed treatment.

J. Infection Control for Individuals in SLA Settings

1. Universal Standard Precautions will be observed in SLA environments by all staff. Service recipients will be encouraged and supported to follow those guidelines.
2. The ISP Team will address and develop support plans related to risk for infection as applicable to the individual.

Attachments (Click Below)

DS-ISP-15 (A)
DS-ISP-15 (B)
39 – 2 Medication Administration in Developmental Services SLA
DS- ASS-01
DS-LC-01
DS-LC-02

Approved By		
Title	Signature	Date
Deputy Administrator	Michele Fenaell	4/17/15
Division Administrator or Designee		

Document History		
Revision	Date	Change

POLICY

DS Regional Centers will meet the needs of individuals served through consistently developed and fiscally responsible cost of living allowances for individuals receiving residential services.

PURPOSE

The purpose of this policy is to provide Regional Center staff with reasonable and consistent guidelines in the development of authorizations related to cost of living allocations to ensure that individuals receiving residential services are being supported through an equitable process, as well as to clarify specific responsibilities of the individual, the Regional Center and Provider in regards to use of resources and benefits. This policy applies to residential setting with exception of Host Home and Intermittent Supported Living Services received in family homes. (Refer to ADSD Policy 41-5 for guidelines on Host Home cost of living allocations).

REFERENCES

Code of Federal Regualtions: Title 42 Part 483.430

Nevada Developmental Service Program Rates

Medicaid Service Manual - Chapter 2100

Nevada's Home and Community Based Waiver (HCBW) Conditions of Agreement for Persons with Intellectual Disability and Related Conditions

PROCEDURE

A. RESOURCES

1. The individual's' resources are the first source of revenue used in authorization of cost of living allocations. Resources include the individual's' benefits (SSI, SSDI), trust funds, retroactive benefits, or work income (retained earnings). Individuals are approved to retain 20% of work income (up to a maximum of $200) to use for discretionary funds. All other income will be used to cover personal expenses to include: personal needs, food, utilities, and phone. If individual resources cover all four of these categories in entirety, then there resources will be utilized towards other room and board areas on the authorization. State funds will be allocated to any room and board area of the authorization, except for retained earnings, not fully covered by the individual's resources.

B. HOUSING

1. Regional Center Responsibility
    a. The cost of housing, to include motel, apartment and single dwelling homes, will be limited to Housing and Urban Development (HUD) fair market value or a maximum of $700.00 per person per month, whichever is less. If the individual chooses to exceed the designated amount, the individual/family/guardian/provider will be solely responsible for the additional costs above the maximum amount unless otherwise approved by the Regional Center Program Manager or designee.

b. The Regional Center may make available limited funding to assist with paying for furnishings, deposits, first and last month's rent and cleaning needs. Furniture purchased by the Regional Center for the common areas must remain in the 24-hour Intensive Supported Living Arrangement (ISLA) when the individual served moves out. Bedroom furniture may follow the individual if he/she moves into another residential services setting. If the individual exits the SLA program, bedroom furniture purchased by the Regional Center will remain in the ISLA home.
c. Twenty-four hour supported living environments will be limited to a minimum of three (3) and maximum of four (4) occupants, each with their own bedroom, unless otherwise authorized by the Regional Center Manager or designee.

2. Provider Responsibility

a. Housing used for supported living services must be located in integrated community neighborhood settings.
b. Individual/organizational provider agencies (including subsidiaries, family and employees) may not have financial interest in homes in which the agency has a contract for supported living services unless otherwise authorized by the Regional Center Program Manager or designee.
c. It will be the responsibility of the provider to apply for all low income housing alternatives (HUD).
d. It will be the responsibility of the provider to communicate the amount of an individual's benefits to the Regional Center. Benefits will be used to offset the cost of room and board. Changes in a benefit amount may result in an amended cost allocation authorization.
e. It will be the responsibility of the provider to collect outstanding deposits on behalf of individual choosing to relocate to an alternative residence. Returned deposits will be used towards the deposit on a new residence if the individual continues to receive residential services support. If it is not possible to use the money towards a new deposit, or the individual leaves the residential services program, the deposit will be returned to the original funding source.
f. It will be the responsibility of the provider to set up an appropriate sleeping environment for staff in homes authorized to provide sleep supervision.

C. UTILITIES/PHONE/CABLE

1. Regional Center Responsibility

a. The cost of utilities, to include power, gas, water, sewer and trash, will be limited to $140.00 maximum per person per month during the initial six months of residence. In areas requiring the purchase of propane or experiencing other unique costs, the cost of utilities will be limited to $200.00 maximum per person per month during the initial six months of residence. If additional funding is needed the Regional Center will request a copy of all utility bills and authorize the average over a 12 month period. Exceptions to this will be authorized by the Regional Center Agency Manager or designee.
b. Phone service will be limited to the basic plan service rate per home. Cell phones or long distance call reimbursement not to exceed $30.00 per month.
c. Cable or satellite television and internet service will be paid by individuals desiring the service.

2. Provider Responsibility

a. It will be the responsibility of the provider to assist individuals in applying for public assistance services to include but not limited to, HUD, low income energy assistance, equal payment plane and any other community resource available to support individuals funded by the Regional Centers. All 24-hour supported living environments should be fitted with a programmable thermostat that is consistent with utility company recommended temperature for the individual's community. The temperatures must be set for the absence of individuals in the home during the work day. Installation costs may be reimbursed by the Regional Center.
b. It will be the responsibility of the provider to communicate the amount of benefits or low income assistance to the Regional Center upon approval of the assistance program. If this reduction in cost is not reported to the Regional Center upon the date of approval, the Regional Center will ask the provider to reimburse the state the full amount. Benefits will be used to offset the cost of room and board in the cost allocation authorization. All reduced resources will be deducted from the standard amount authorized on the cost allocation.
c. It will be the responsibility of the provider to complete all applications for the above services within 60 days of the individual's move-in date, maintain eligibility and notify the assigned Service Coordinator of the eligibility date.

D. **FOOD**

1. Regional Center Responsibility

   a. Food Expense allocation is adjusted annually based on the USDA Average (January current year) USDA Food Plans: Cost of Food at Home at four levels- amount for adults (20 to 50 years of age-) males and females for the low cost monthly plan as shown on the USDA Table. –The USDA table can be found at: www.cnpp.usda.gov. On an individual basis, and based on health needs of the individual, the pre-determined amount may be increased at the discretion of the PCP Team. This justification will be documented in the PCP and approved by the Regional Center Program Manager or designee prior to allocation of additional funds.

2. Provider Responsibility

   a. It is the responsibility of the provider to assist the individual in applying for additional assistance or benefits (such as food stamps). Provider staff will support individuals in comparison shopping, use of coupons, or food bank resources.
   b. It is the responsibility of the provider to inform the Regional Center Service Coordinator when an individual is receiving food stamps, including the dollar amount of the food stamp allotment. Changes in benefit amount will result in an amended cost allocation authorization.
   c. Provider staff must provide their own food, or purchase thereof, when working in the home or at a community activity.

E. **ONE TIME COSTS**

1. One-time costs may be added to the cost allocation authorization. Eligible conditions for a one-time cost include, but are not limited to: dental cleanings and/or work; startup costs for utilities; deposits; furniture; medical expenses; emergency transportation; and specialized camps.

2. One-time costs may also be authorized for individual requirements for program needs, which allow funds for a provider to be reimbursed for the costs of a direct support staff attending an activity with a person supported. Examples include staff attendance at a movie, baseball game, concert or other special event.
3. Special one-time costs may be authorized when a person supported is traveling on vacation but cannot safely travel alone. The Regional Center Program Manager or designee may authorize one-time costs to pay for support personnel to safely accompany that person during travel. This might include costs for hotel, transportation, and other associated expenses. In this circumstance, the need for a one time cost must be justified and defined in the Person Centered Plan and prior authorized by the Regional Center Program Manager or designee.
4. It will be the provider's responsibility to ensure all receipt and documentation for one-time costs are submitted prior to reimbursement.

F. TRANSPORTATION

1. Regional Center Responsibility
   a. In those areas with public bus transportation, transportation costs shall not exceed the actual cost of a bus ticket(s)/ bus pass per trip.
   b. Transportation costs may be utilized toward the cost of home vehicles, gas, maintenance and/or licensure in lieu of purchasing public transportation. This must be approved by each team and written in the Person Centered Plan.
2. Provider Responsibility
   a. It is the responsibility of the provider to assist all individuals in accessing community activities through natural means if applicable i.e. learning to ride bus, ride sharing, or informal supports.
   b. Providers will not be reimbursed for staff commute time to and from individual's living environment, work/school or community activity.

G. ITEMS WHICH CANNOT BE PURCHASED WITH STATE MONEY/THROUGH A STATE COST OF LIVING ALLOCATION

1. Neither state nor waiver funds may be utilized to purchase items which are illegal.
2. Cost allocation authorizations will not be increased when individuals may have misused their funds on such items as gambling, purchasing pornography, alcohol, visiting strip clubs or brothels, etc., and cannot pay rent and/or utilities

ATTACHMENTS (CLICK BELOW)

None

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
AGING AND DISABILITY SERVICES DIVISION				
2016 POLICY MANUAL				
POLICY #	**REVISED**	**TITLE**	**EFFECTIVE DATE**	**PAGE**
41 - 4	**12/11/2015**	**Residential Services Cost of Living Allocations**	3/15/2013	**1 of 5**

Approved By		
Title	Signature	Date
Deputy Administrator Cara Pasola		5/25/16
Division Administrator or Designee		

Document History

Revision	Date	Change

POLICY

This policy applies to Developmental Services (DS) shared living caregivers providing residential support services in Shared Living arrangements, who currently do not fall under an Administering Agency, prior to January 2013. It is the policy of DS to provide structure and standards for the provision of residential habilitation services in Shared Living arrangements.

PURPOSE

To provide specific guidelines for the protection, health and welfare of individuals with developmental disabilities, through the formation, implementation and enforcement of minimum requirements for providers of residential habilitation services in a Shared Living arrangement.

DEFINITIONS

Administering Agency: A DS Regional Center certified provider organization of supported living services that provides essential administrative oversight and support services to Shared Living providers, such as recruitment, approval to become a provider, quality assurance, training and other such functions.

Legally Responsible Individuals (LRI): Persons who are legally responsible to provide medical support, including spouses of individuals, legal guardians, and parents of minors receiving services including adoptive parents, stepparents, and foster parents. LRI's cannot receive payment for the provision of residential support services.

Natural Supports: Natural supports are the relationships and activities that occur in everyday life. Natural supports usually involve family, household members, friends, co-workers, neighbors and acquaintances who provide unpaid assistance as part of the natural relationship. Examples include supervision and support with activities of daily living.

Person Centered Plan (PCP): A document and working tool that identifies the individual's interests, personal goals; health and welfare needs; and agreed upon supports and services that are to be provided through a variety of programs to include Medicaid State Plan, Medicaid Waiver, natural and informal supports, generic community resources and contracted services.

Relative/Immediate Family: Biological or adoptive family members, including but not limited to stepparents, grandparents, great grandparents, siblings, aunts, uncles, nieces, nephews, cousins, and children.

Residential Support Services: Individually planned and coordinated services designed to ensure the health and welfare of the individual, and to assist in the acquisition, retention and improvement in skills necessary to support the person to successfully reside in the community. Residential Support Services are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, are available to supplement those support systems.

Shared Living Arrangement: An arrangement in which a person, a couple or a family in the community and an individual with a disability choose to live together and share life's experiences.

Shared Living Provider: A self-employed person that provides residential support services to an individual with disabilities when both parties have chosen to live together in a Shared Living arrangement. A provider who brings an individual into his/her existing home in a Shared Living arrangement may not be an employee of the individual or the individual's representative.

REFERENCES

Nevada Revised Statute (NRS) 435

Nevada Administrative Code (NAC)

Medicaid Services Manual (MSM) Chapters 100 and 2100

ADSD Policy

Developmental Services Respite Policy

PROCEDURE

A. PROVIDER QUALIFICATIONS & CONTRACTING

1. Persons providing residential support services in Shared Living arrangements. The identified care provider must meet all qualifications outlined in Nevada Revised Statute (NRS) 435, Nevada Administrative Code (NAC) 435 and the Medicaid Services Manual (MSM) Chapters 100 and 2100, which include, but are not limited to:
   a. Compliance with State and Federal regulatory requirements, including but not limited to, pertinent requirements as set forth by:
      1) Centers for Medicare and Medicaid Services (CMS)
      2) Division of Health Care Finance and Policy (DHCFP)
      3) Aging and Disability Services Division policies and procedures
      4) Disability Services Regional Center policies and procedures
   b. Meet all the requirements to be enrolled and are in good standing as a Medicaid Provider (type 38), including maintaining required training and criminal clearance checks pursuant to MSM Chapters 100 and 2100;
   c. Maintain certification by Nevada Developmental Services pursuant to NRS 435, NAC 435 and ADSD Policy and Procedure.
2. Shared Living providers must demonstrate and maintain ability to fully utilize ADSD's information management technology and must have a computer and hardware that is compatible with the ADSD information management system. It is the responsibility of the Shared Living provider to purchase the requisite equipment.
3. Shared Living providers must enter into the Provider Agreement for Residential Support Services with ADSD;
4. Failure to meet these requirements may result in termination of the Provider Agreement or application of sanctions, including requiring the Shared Living provider to subcontract with a DS certified Administering Agency.

B. PERSON CENTERED PLANNING

1. Nevada DS utilizes the person centered planning process to develop supports and services to all individuals. Providers of Shared Living are required to participate in the person centered planning process.
2. At least annually the support team, including the individual served, people chosen by the individual (i.e. family/friends), the DS Service Coordinator, Shared Living provider, JDT

provider, and guardian will develop a person centered plan that will identify all the paid and natural supports and services the person needs and desires in order to achieve his or her desired outcomes. Residential support services are not a replacement for the natural supports provided by family, friends, household members, etc.

3. All paid supports provided by the Shared Living provider will be included in the individual's person centered plan and will include the scope and frequency of services and supports to be provided.
4. The Shared Living provider works with the individual to develop integrated daily life routines and schedules within the home. The Shared Living provider is expected to exercise control over their work.
5. The Shared Living provider is responsible to make investments to obtain home modifications and maintain their home in a manner to meet the needs of the individual. This includes the installation of environmental modifications such as ramps, grab bars, etc.

C. SERVICE AUTHORIZATION & PAYMENT

1. The DS Service Coordinator will authorize all residential support services pursuant to the person centered plan.
2. Individuals receiving residential support services from non-relatives/non-immediate family members in a Shared Living arrangement where they are the only service recipient may only be authorized for up to 260 hours per month of services per month. Individuals who receive residential support services in a Shared Living arrangement where there are two service recipients may only be authorized up to 175 hours per month per individual served in the Shared Living arrangement. Residential support services are not a replacement for natural supports.
3. Individuals receiving residential support services from relatives/immediate family members in a Shared Living arrangement may be authorized up to 175 hours per month.
4. The rate for residential support provided by a Shared Living provider is the current approved DS rate for residential support services to independent providers. DS does not provide reimbursement for overnight supervision for individuals receiving residential support services in a Shared Living arrangement.
5. Providers of Shared Living are required to maintain a daily log and progress report that meets the Home and Community Based Waiver requirements. Daily records of residential support services must be completed at the time of service.
6. Providers of Shared Living must disclose if they are providing any Personal Care Services (PCA) to the individual they are living with funded through the Medicaid State Plan to the DS Regional Center Service Coordinator. DS will not contract for services that are covered by PCA services. A copy of the PCA plan and authorization must be kept in the individual record as part of the person's PCP to ensure there is not duplication of services.
7. Providers of Shared Living are responsible for accurate and timely billing the DS Regional Center for services provided.
8. DS is responsible for authorizing residential services pursuant to the person centered plan and compensating the Shared Living provider for services rendered and billed. The DS Regional Center will only provide payment for services accurately billed and justified with accurate daily records.

9. No legally responsible individual may be reimbursed for services to their child, ward, or spouse.
10. Individuals in independent Shared Living arrangements may qualify for respite funding (refer to Developmental Services Respite Policy). When respite services are utilized, the Shared Living provider may not bill the DS Regional Center for residential support services.
    a. Room and Board in any Shared Living arrangement setting will be determined as follows:
        1) The resources of the individual served, including, but not limited to, Social Security benefits, food stamps and employment earnings, will be the total resources available for Room and Board costs. State supplements for Room and Board are only utilized if the individual's resources are not sufficient to cover basic costs and must be approved by the DS Regional Center Program Manager.
        2) Individuals will receive the current standard allotment for food and personal needs monies, as determined annually by the DS Regional Centers.
        3) Individuals will retain 20% of any employment earnings, up to a maximum of $200 monthly, to use for additional personal needs money.
        4) The DS Regional Center will not provide funding for furnishing the home or costs for damages incurred, unless prior authorized by the DS Regional Center Agency Manager or designee.
        5) Amounts approved for rent, utilities and phone will be determined based on Housing and Urban Development (HUD) fair market value, actual costs and the total number of adults and children residing the home. Housing costs are split between all adults living in the home.

D. MONITORING SHARED LIVING PROVIDERS

1. DS ensures compliance with the Shared Living Arrangements Policy, Standards of Service Provision, Home and Community Based Waiver, and current ADSD and DS Regional Center and policies.
2. DS oversees quality management and monitors compliance with certification and other requirements.
3. The DS Regional Center Service Coordinator will conduct a home visit at least every three (3) months to monitor the individual's progress in the specific Shared Living arrangement site, and to ensure that the Shared Living provider is delivering the supports in accordance with the provider standards. The Service Coordinator will document the following:
    a. Available supports, care, and treatment. This includes, but is not limited to the needs addressed in the PCP.
    b. Human and Civil Rights are maintained.
    c. Oversight of self-administration of medication (if applicable) or that the administering of medication follows applicable laws, rules and regulations.
    d. Person Centered focus is evident.
    e. Daily logs are completed timely and accurately.

f. Information and documentation management is protected, secure, organized and confidential.

g. The Shared Living provider and other family or household members, as applicable, demonstrate respect for the individual(s) served and include the individual in the day to day family routines.

h. Assessment of the physical environment, review of disaster and fire safety plan, required training, community inclusion, personal funds, and vehicle transportation.

4. The DS Regional Center Service Coordinator will organize a visit monthly contact with the individual, in order to verify health, safety and welfare and progress toward the Person Centered Plan.

5. The DS Quality Assurance Department will complete a comprehensive environmental review of the home at least annually. A copy of the review results and a written summary of corrections implemented are kept in the Shared Living provider record for at least one (1) calendar year.

6. DS Regional Center Quality Assurance staff will complete certification and other quality reviews, as per NAC 435. This will include, but is not limited to, environmental reviews of Shared Living environments, review of records, and interviews with Shared Living providers, individuals served, guardians and DS Service Coordinators

   a. DS Regional Center staff may conduct unannounced home visits and investigations at any time. DS Regional Center staff has the authority to examine quality of care and support delivery, the individual's records, physical premises, including the condition of the home grounds, equipment, food, water supply, sanitation, maintenance, housekeeping practices and any other areas necessary to determine compliance with standards.

7. In the event there is an allegation of abuse, neglect or exploitation and the Shared Living provider is the alleged perpetrator, the DS Regional Center will immediately place the individual(s) served in a respite setting until completion of the investigation to ensure the health, safety and welfare of the individual(s) served. The Shared Living provider will not be provided reimbursement for services while the individual(s) is placed in respite.

E. TERMINATION OF CONTRACT BETWEEN THE SHARED LIVING PROVIDER AND DEVELOPMENTAL SERVICES:

1. When a Shared Living provider no longer wants to provide services to the individual and/or wants to end its agreement with the DS Regional Center, they must give at least a thirty (30) written day notice to:

   a. The individual(s) served and guardian, as applicable; and The DS Regional Center.

   b. When a Shared Living provider initiates termination and ends the agreement with DS, the Shared Living provider must assist the DS Regional Center in efforts to facilitate a successful transition.

2. The Shared Living provider is expected to continue working for thirty (30) days unless otherwise determined by DS Regional Center.

3. Once the individual moves from the Shared Living arrangement, the Shared Living provider must apply through a DS certified Administering Agency if they wish to continue to residential support services in a Shared Living arrangement.

4. If an emergency occurs and services must be terminated immediately, the Shared Living provider must give immediate notice to DS Regional Center.
5. DS Regional Center may terminate a contract for cause at any time. If the Shared Living provider is unable to meet required standards, Development Services may initiate sanctions including requiring the Shared Living provider to subcontract with a DS certified Administering Agency.

ATTACHMENTS

Not applicable

Approved By		
Title	Signature	Date
Deputy Administrator		6/30/16
Division Administrator or Designee		6/30/16

Document History

Revision	Date	Change

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
AGING AND DISABILITY SERVICES DIVISION				
2016 POLICY MANUAL				
POLICY #	**REVISED**	**TITLE**	**EFFECTIVE DATE**	**PAGE**
46 - 1		**Developmental Services Electronic Documentation**	Upon Approval	**1 of 4**

POLICY

Developmental Services electronic record documentation will be accurate, timely, and completed in compliance with federal and state Medicaid guidelines, and any other relevant federal and state law and regulation.

PURPOSE

To establish procedures for entering information into the Developmental Services electronic record system which ensure the clear and timely documentation of information regarding individuals served.

DEFINITIONS

Harmony: The name of the electronic record data base system utilized by Developmental Services.

Billable Code: Service time entered into the Harmony notes system which is reimbursable from Medicaid.

DAP Format : Case note format where the writer addresses each of three areas:

1) Data/Description (D) – which includes: what was said or observed; issues reported and other data exchanged during the contact; intervention offered.
2) Assessment (A) – which includes: what occurred, what was achieved; client response to intervention; risk factors, and
3) Plan (P) – which includes: actions to be taken in relation to what is documented in "data" section and consumer's goals, date of next meeting, and planned follow-up.

REFERENCES

NAC 435

NRS 435

Medicaid Waiver Chapter 2100, Chapter 2500, and chapter 100

HIPAA

ADSD Policy 33 – 1 Confidentiality

PROCEDURE

A. ELECTRONIC RECORD ACCOUNTS

1. All DS program staff will have accounts for Harmony. ADSD personnel staff will submit a request to the ADSD IT Help Desk at least two (2) weeks prior to a new employee start date of the need for these accounts. Personnel will indicate to IT the staff person's job title. IT will assign the appropriate level of permissions for Harmony according to job title. Staff will be informed during orientation by his/her supervisor of his/her level of access to Harmony.
2. Intake staff will create a Harmony account for all individuals who have completed an intake application within three (3) working days of receipt of the completed application.

B. GENERAL DOCUMENTATION PROCEDURES

1. Staff will document activities within five business days of the activity, assuring that each field is complete and accurate. Once a note is completed, staff should mark the note as "complete" in the Harmony system.
2. Staff will mark all notes as "complete" within the five business day requirement.

C. HARMONY NOTES

1. Case Management Note Types
   a. Three note templates are utilized in Harmony for Case Management notes. Case Management notes are completed by Nurses, Clinicians, and Targeted Case Managers. The note types are:
      1) DAP Note: utilized when indicating Data/Assessment/Plan
      2) Narrative
      3) Service Coordinator Contact Note: utilized by Targeted Case Managers to indicate a monthly, quarterly, or Person-Centered-Plan meeting contact.
   b. Targeted Case Management Note Types
      1) TCM: Assessment
      2) TCM: Service Planning
      3) TCM: Referral
      4) TCM: Monitoring
      5) TCM: Other Contact
   c. Clinical Note Types
      1) Psych Svcs: Other Assessment (MS/PhD)
      2) Psych Svcs: Individual Therapy (MS/PhD)
      3) Psych Svcs: Group Therapy (MS/PhD)
      4) Psych Svcs: Consultation (MS/PhD)
      5) Psych Svcs: Eligibility Assessment (MS/PhD)
      6) Psych Svcs: Eligibility Assessment (BS)
      7) Psych Svcs: Behavioral Consultation (MS/PhD)
      8) Psych Svcs: Behavioral Consultation (BS)
      9) Psych Svcs: Other Medical Record Information (BS)
      10) Psych Svcs: Other Medical Record Information (MS/PhD)
   d. Nursing Note Types
      1) Nursing: Assessment Comprehensive (RN)
      2) Nursing: Assessment Update (RN)

3) Nursing: Consultation (RN)
4) Nursing: Direct Services (RN)
5) Nursing Rural: Assessment Comprehensive (RN)
6) Nursing Rural: Assessment Update (RN)
7) Nursing Rural: Consultation (RN)
8) Nursing Rural: Direct Services (RN)
9) Nursing: Direct Services (LPN)
10) Nursing Rural: Direct Services (LPN)
11) Nursing Rural: Other Medical Record Information (LPN)
12) Nursing: Other Medical Record Information (LPN)
13) Nursing Rural: Other Medical Record Informaiton (RN)
14) Nursing: Other Medical Record Information (RN)

2. Documentation Notes
   a. Documentation notes are used to upload specific documents and information into Harmony; examples include medical information, birth certificates, reports from other professionals, etc
   b. Documentation notes are not a substitute for entering a Case Management note. When required, a Case Management note will be entered as well as a Documentation note.
3. Documenting Time
   a. Harmony requires that all Case Management notes utilize a "start time" and "end time". Documentatoin Notes do not require a "Start Time" and "End Time" but do require a "Note Date".
   b. The writer will utilize the "start time" and "end time" to indicate the time frame when the activity occurred.
   c. Time spent on an activity includes the activity itself and the time it takes to enter the note. Time spent on an activity will be rounded to the nearest 15 minute unit as outlined in Attachment A.
   d. An employee who works with multiple individuals in a given time frame will divide the time spent by the number of people served, and enter the number of minutes per person as outlined in Attachment A.

D. MEDICAID AND SOCIAL SECURITY NUMBERS

1. Federal and state HIPAA and confidentiality regulations protect the individual who is receiving services and ensures that information shared by them or gathered by the Division will be used constructively on his/her behalf. The Division must provide protection against improper disclosure, and must share pertinent information with appropriate persons at appropriate times in order to provide the best possible service. It is the obligation of Division staff to follow federal regulations and state statutes that protect privacy and prohibit the unwarranted disclosure of information, particularly Medicaid and Social Security numbers.

a. The "Medicaid Number" field is a required field in Harmony. This field must be updated timely any time the individual's Medicaid benefit status changes. For individuals who do not receive Medicaid staff will enter 11 "X's" into the field as follows: "XXXXXXXXXXX". For individuals receiving Medicaid, the 11 digit number is entered.

b. The "Social Security Number" field is a required field. If an individual wishes to apply for services and their social security number is not made available, Intake staff will enter "000-00-0000" to indicate that no number was provided. This field must be updated timely by intake staff prior to opening the case and assignment to a service coordinator.

ATTACHMENTS (CLICK BELOW)

Attachment A – Documentation of Time Spent on an Activity

Approved By		
Title	Signature	Date
Deputy Administrator		6/17/16
Division Administrator or Designee		6/17/16

Document History		
Revision	Date	Change